AMENDED IN ASSEMBLY APRIL 12, 2005

CALIFORNIA LEGISLATURE—2005–06 REGULAR SESSION

ASSEMBLY BILL No. 651

Introduced by Assembly Member Levine

February 17, 2005

An act to amend Sections 14132.27 and 14132.100 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 651, as amended, Levine. Medi-Cal: disease management.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services and under which qualified low-income persons receive health care services.

Existing law requires the department to develop and apply for a waiver of federal law to test the efficacy of providing a disease management benefit to beneficiaries under the Medi-Cal program. Existing law requires this waiver, known as the Disease Management Waiver, to meet certain design requirements and specifies eligibility requirements. Existing law requires the department to evaluate the effectiveness of the waiver and submit the evaluation to the Legislature on or before January 1, 2008.

This bill would require the waiver to include at least one demonstration that evaluates the chronic care model for treating people with chronic diseases in community-based *and public hospital system* primary care settings and would authorize other demonstrations under the waiver that meet certain requirements. The bill would extend the deadline for submission of the evaluation of the waiver to the Legislature to January 1, 2009.

Existing law defines a visit for purposes of services provided by a federally qualified health center (FQHC) or a rural health clinic (RHC) under the Medi-Cal program.

This bill would define visit to also include a face-to-face encounter between a FQHC or RHC patient and a chronic disease management practitioner under the Disease Management Waiver provisions.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 14132.27 of the Welfare and Institutions Code is amended to read:

14132.27. (a) (1) The department shall apply for a waiver of federal law pursuant to Section 1396n of Title 42 of the United States Code to test the efficacy of providing a disease management benefit to beneficiaries under the Medi-Cal program. A disease management benefit shall include, but not be limited to, the use of evidence-based practice guidelines, supporting adherence to care plans, and providing patient education, monitoring, and healthy lifestyle changes.

(2) The waiver developed pursuant to this section shall be known as the Disease Management Waiver. The department shall submit any necessary waiver applications or modifications to the Medicaid State Plan to the federal Centers for Medicare and Medicaid Services to implement the Disease Management Waiver, and shall implement the waiver only to the extent federal financial participation is available.

(b) The Disease Management Waiver shall include at least one demonstration that evaluates the chronic care model. This chronic care model demonstration shall provide a range of services to improve quality of care for individuals with chronic diseases in community-based *and public hospital system* primary care settings.

(1) The following definitions shall apply to the chronic care model demonstration:

~~(A) "Chronic care model"means a national model developed by the MacColl Institute~~

(A) "Chronic care model" means the national Health Disparities Collaboratives model from the United States

Department of Health and Human Services, Health Resources and Services Administration that synthesizes six essential elements of a health care system to promote high-quality chronic disease care. These elements foster productive interactions between informed patients who take an active part in their health care and providers with resources and expertise. The effectiveness of the chronic care model of disease management is assessed through quantitative health outcome data collection and qualitative assessment of innovations that result in improved patient health outcomes.

(B) "Chronic disease management provider" means any clinic defined in subdivision (a) of Section 1204 of the Health and Safety Code or that is exempt from licensure under subdivision (h) of Section 1206 of the Health and Safety Code, *or a freestanding or hospital-based clinic owned or operated by a public hospital or public health system, or a freestanding or hospital-based clinic owned or operated by a hospital that maintains the primary contract with a county government to fulfill the county's role pursuant to Section 17000,* that is utilizing the chronic care model.

(2) Eligibility for the chronic care model demonstration shall be limited to those persons who are eligible for the Medi-Cal program and who are determined by the department to be at risk of, or who have been diagnosed with, diabetes or asthma. Eligibility shall be based on the individual's medical diagnosis and prognosis and other criteria, as specified in the waiver.

(3) The chronic care model demonstration shall be piloted on a county basis. The selection of pilot counties shall be based on the availability of chronic disease management providers and the extent of experience these providers have with the chronic care model. There shall be a mix of rural and urban counties chosen for the demonstration.

(4) Services provided pursuant to the chronic care model demonstration shall include only those services not otherwise available under the state plan. The chronic disease management provider shall track patients with chronic diseases and schedule visits with appropriate providers. As a condition of reimbursement for coordinating these services, the chronic disease management provider shall ensure the provision of all of

the following services either through the provider's own service or through subcontracts with or referrals to other providers.

(A) Nutrition assessments.

(B) Health education.

(C) Education on medication management, nutrition, and physical fitness.

(D) Care management, including medication and case management.

(E) Psychosocial assessments.

(F) Evidence-based practice guidelines.

(G) Development of a care plan.

(5) The chronic disease management provider may employ or contract with all of the following medical and other practitioners for the purpose of providing chronic disease management services:

(A) Physicians.

(B) Physician assistants.

(C) Nurse practitioners.

(D) Nurses.

(E) Social workers, psychologists, and marriage and family therapists.

(F) Health educators.

(G) Optometrists.

(H) Podiatrists.

(I) Physical therapists.

(J) Pharmacists.

(K) Community health workers.

(L) Medical assistants.

(M) Certified diabetic educators.

(6) The department shall establish a method of reimbursement of chronic disease management providers that shall include a fee for coordinating services and be sufficient to cover reasonable costs for the provision of chronic disease management services. Federally qualified health centers and rural health clinics shall be reimbursed according to subdivision (c) of Section 14132.100.

(c) The department may also pursue other demonstrations as part of the Disease Management Waiver. Each of these demonstrations shall meet all of the following requirements:

(1) The demonstration shall be designed to provide eligible individuals with a range of services that enable them to remain in

the least restrictive and most homelike environment while receiving the medical care necessary to protect their health and well-being. Services provided pursuant to the demonstration shall include only those not otherwise available under the state plan, and may include, but are not limited to, medication management, coordination with a primary care provider, use of evidence-based practice guidelines, supporting adherence to a plan of care, patient education, communication and collaboration among providers, and process and outcome measures. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waiver.

(2) Eligibility for the demonstration shall be limited to those persons who are eligible for the Medi-Cal program as aged, blind, and disabled persons or those persons over 21 years of age who are not enrolled in a Medi-Cal managed care plan, or eligible for the federal Medicare program, and who are determined by the department to be at risk of, or diagnosed with, select chronic diseases, including, but not limited to, advanced atherosclerotic disease syndromes, congestive heart failure, and diabetes. Eligibility shall be based on the individual's medical diagnosis and prognosis, and other criteria, as specified in the waiver.

(3) In undertaking the demonstration, the director may enter into contracts for the purpose of directly providing disease management services.

(d) The Disease Management Waiver shall test the effectiveness of providing a Medi-Cal disease management benefit. The department shall evaluate the effectiveness of each demonstration of the Disease Management Waiver.

(1) The evaluation shall include, but not be limited to, participant satisfaction, health and safety, the quality of life of the participant receiving the disease management benefit, and demonstration of the cost neutrality of the Disease Management Waiver as specified in federal guidelines.

(2) The evaluation shall estimate the projected savings, if any, in the budgets of state and local governments if each demonstration of the Disease Management Waiver was expanded statewide.

(3) The evaluation shall be submitted to the appropriate policy and fiscal committees of the Legislature on or before January 1, 2009.

(e) The ~~department shall limit the~~ number of participants in the Disease Management Waiver during the initial three years of its operation ~~to a number that will~~ *shall* be statistically significant for purposes of the waiver evaluation and ~~that meets~~ any requirements of the federal government, including a request to waive statewide implementation requirements for the waiver during the initial years of evaluation.

(f) The department shall seek all federal waivers necessary to allow for federal financial participation under this section.

(g) The Disease Management Waiver shall be developed and implemented only to the extent that funds are appropriated or otherwise available for that purpose.

(h) The department shall not implement this section if any of the following apply:

(1) The department's application for federal funds under the Disease Management Waiver is not accepted.

(2) Federal funding for the waiver ceases to be available.

SEC. 2. Section 14132.100 of the Welfare and Institutions Code is amended to read:

14132.100. (a) The federally qualified health center services described in Section 1396d(a)(2)(C) of Title 42 of the United States Code are covered benefits.

(b) The rural health clinic services described in Section 1396d (a)(2)(B) of Title 42 of the United States Code are covered benefits.

(c) Federally qualified health center services and rural health clinic services shall be reimbursed on a per-visit basis in accord with the definition of "visit" set forth in subdivision (g).

(d) Effective October 1, 2004, and on each October 1, thereafter, until no longer required by federal law, federally qualified health center (FQHC) and rural health clinic (RHC) per-visit rates shall be increased by the Medicare Economic Index applicable to primary care services in the manner provided for in Section 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to January 1, 2004, FQHC and RHC per-visit rates shall be adjusted by the Medicare Economic Index in accord with

the methodology set forth in the state plan in effect on October 1, 2001.

(e) (1) An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC. Rate changes based on a change in the scope of services provided by an FQHC or RHC shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(2) Subject to the conditions set forth in subparagraphs (A) to (D), inclusive, of paragraph (3), a change in scope of service means any of the following:

(A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate.

(B) A change in service due to amended regulatory requirements or rules.

(C) A change in service resulting from relocating or remodeling an FQHC or RHC.

(D) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

(E) An increase in service intensity attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(F) Any changes in any of the services described in subdivision (a) or (b), or in the provider mix of an FQHC or RHC or one of its sites.

(G) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in subdivisions (a) or (b), including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(H) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.

(I) Any changes in the scope of a project approved by the federal Health Resources and Service Administration (HRSA).

(3) No change in costs shall, in and of itself, be considered a scope-of-service change unless all of the following apply:

(A) The increase or decrease in cost is attributable to an increase or decrease in the scope of services defined in subdivisions (a) and (b), as applicable.

(B) The cost is allowable under Medicare reasonable cost principles set forth in Part 413 (commencing with Section 413) of Subchapter B of Chapter 4 of Title 42 of the Code of Federal Regulations, or its successor.

(C) The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof.

(D) The net change in the FQHC's or RHC's rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75 percent threshold shall be applied to the average per-visit rate of all sites for the purposes of calculating the cost associated with a scope-of-service change. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

(4) An FQHC or RHC may submit requests for scope-of-service changes once per fiscal year, only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(5) An FQHC or RHC shall submit a scope-of-service rate change request within 90 days of the beginning of any FQHC or RHC fiscal year occurring after the effective date of this section, if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope of services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If an FQHC or RHC discontinues providing onsite pharmacy or dental services, it shall submit a scope-of-service rate change request within 90 days of the beginning of the following fiscal year. The

rate change shall be effective as provided for in paragraph (4). As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

(6) Notwithstanding paragraph (4), if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of-service change, the adjusted reimbursement rate for that scope-of-service change shall be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph shall be required to be submitted within the later of 150 days after the adoption and issuance of the written instructions by the department, or 150 days after the end of the FQHC's or RHC's fiscal year ending in 2003.

(7) All references in this subdivision to "fiscal year" shall be construed to be references to the fiscal year of the individual FQHC or RHC, as the case may be.

(f) (1) An FQHC or RHC may request a supplemental payment if extraordinary circumstances beyond the control of the FQHC or RHC occur after December 31, 2001, and PPS payments are insufficient due to these extraordinary circumstances. Supplemental payments arising from extraordinary circumstances under this subdivision shall be solely and exclusively within the discretion of the department and shall not be subject to subdivision (*l*). These supplemental payments shall be determined separately from the scope-of-service adjustments described in subdivision (e). Extraordinary circumstances include, but are not limited to, acts of nature, changes in applicable requirements in the Health and Safety Code, changes in applicable licensure requirements, and changes in applicable rules or regulations. Mere inflation of costs alone, absent extraordinary circumstances, shall not be grounds for supplemental payment. If an FQHC's or RHC's PPS rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, then a supplemental payment is not warranted.

(2) The department shall accept requests for supplemental payment at any time throughout the prospective payment rate year.

(3) Requests for supplemental payments shall be submitted in writing to the department and shall set forth the reasons for the request. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which supplemental payment is requested meet the requirements set forth in this section. Documentation shall include all of the following:

(A) A presentation of data to demonstrate reasons for the FQHC's or RHC's request for a supplemental payment.

(B) Documentation showing the cost implications. The cost impact shall be material and significant (two hundred thousand dollars ($200,000) or 1 percent of a facility's total costs, whichever is less).

(4) A request shall be submitted for each affected year.

(5) Amounts granted for supplemental payment requests shall be paid as lump-sum amounts for those years and not as revised PPS rates, and shall be repaid by the FQHC or RHC to the extent that it is not expended for the specified purposes.

(6) The department shall notify the provider of the department's discretionary decision in writing.

(g) An FQHC or RHC "visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse. For purposes of this section, "physician" shall be interpreted in a manner consistent with the Centers for Medicare and Medicaid Services' Medicare Rural Health Clinic and Federally Qualified Health Center Manual (Publication 27), or its successor, only to the extent that it defines the professionals whose services are reimbursable on a per-visit basis and not as to the types of services that these professionals may render during these visits and shall include a medical doctor, osteopath, podiatrist, dentist, optometrist, and chiropractor. A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a comprehensive perinatal services practitioner, as defined in Section 51179.1 of Title 22 of the California Code of

Regulations, providing comprehensive perinatal services, a face-to-face encounter between a FQHC or RHC patient and a chronic disease management practitioner as specified in subdivision (b) of Section 14132.27, a four-hour day of attendance at an adult day health care center, and a face-to-face encounter with any other provider identified in the state plan's definition of an FQHC or RHC visit.

(h) If FQHC or RHC services are partially reimbursed by a third-party payer, such as a managed care entity (as defined in Section 1396u-2(a)(1)(B) of Title 42 of the United States Code), the Medicare program, or the Child Health and Disability Prevention (CHDP) program, the department shall reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate, and may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

(i) (1) An entity that first qualifies as an FQHC or RHC in the year 2001 or later, a newly licensed facility at a new location added to an existing FQHC or RHC, and any entity that is an existing FQHC or RHC that is relocated to a new site shall each have its reimbursement rate established in accordance with one of the following methods, as selected by the FQHC or RHC:

(A) The rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or adjacent area with a similar caseload.

(B) In the absence of three comparable FQHCs or RHCs with a similar caseload, the rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or an adjacent service area, or in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics.

(C) At a new entity's one-time election, the department shall establish a reimbursement rate, calculated on a per-visit basis, that is equal to 100 percent of the projected allowable costs to the FQHC or RHC of furnishing FQHC or RHC services during the first 12 months of operation as an FQHC or RHC. After the first 12-month period, the projected per-visit rate shall be increased

by the Medicare Economic Index then in effect. The projected allowable costs for the first 12 months shall be cost settled and the prospective payment reimbursement rate shall be adjusted based on actual and allowable cost per visit.

(D) The department may adopt any further and additional methods of setting reimbursement rates for newly qualified FQHCs or RHCs as are consistent with Section 1396a(bb)(4) of Title 42 of the United States Code.

(2) In order for an FQHC or RHC to establish the comparability of its caseload for purposes of subparagraph (A) or (B) of paragraph (1), the department shall require that the FQHC or RHC submit its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report. FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit to the department a completed report in the format applicable to the prior calendar year. FQHCs or RHCs that have not previously submitted an annual utilization report shall submit to the department a completed report in the format applicable to the prior calendar year. The FQHC or RHC shall not be required to submit the annual utilization report for the comparable FQHCs or RHCs to the department, but shall be required to identify the comparable FQHCs or RHCs.

(3) The rate for any newly qualified entity set forth under this subdivision shall be effective retroactively to the later of the date that the entity was first qualified by the applicable federal agency as an FQHC or RHC, the date a new facility at a new location was added to an existing FQHC or RHC, or the date on which an existing FQHC or RHC was relocated to a new site. The FQHC or RHC shall be permitted to continue billing for Medi-Cal covered benefits on a fee-for-service basis under its existing provider number until it is informed of its new FQHC or RHC provider number, and the department shall reconcile the difference between the fee-for-service payments and the FQHC's or RHC's prospective payment rate at that time.

(j) Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, or in a mobile unit as defined by

paragraph (2) of subdivision (b) of Section 1765.105 of the Health and Safety Code, shall be billed by and reimbursed at the same rate as the FQHC or RHC establishing the intermittent clinic site or the mobile unit, subject to the right of the FQHC or RHC to request a scope-of-service adjustment to the rate.

(k) An FQHC or RHC may elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. These costs shall be adjusted out of the FQHC's or RHC's clinic base rate as scope-of-service changes. An FQHC or RHC that reverses its election under this subdivision shall revert to its prior rate, subject to an increase to account for all MEI increases occurring during the intervening time period, and subject to any increase or decrease associated with applicable scope-of-services adjustments as provided in subdivision (e).

(*l*) FQHCs and RHCs may appeal a grievance or complaint concerning ratesetting, scope-of-service changes, and settlement of cost report audits, in the manner prescribed by Section 14171. The rights and remedies provided under this subdivision are cumulative to the rights and remedies available under all other provisions of law of this state.

(m) The department shall, by no later than March 30, 2004, promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid Services for any waivers that would be necessary to implement this section.

(n) The department shall implement this section only to the extent that federal financial participation is obtained.

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